David A Gabaldon
Name
P.O Box 25265
Albuquerque NM, 87125
Address

KH

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

~~David Anthony Gabaldon~~ Plaintiff
(Full Name)
David Anthony Gabaldon

v.

Department of Justice, Defendant(s)

CASE NO. 16 CV 1035 WPL
(To be supplied by the Clerk)

CIVIL RIGHTS COMPLAINT
PURSUANT TO 42 U.S.C.§1983

A. JURISDICTION

1) David Anthony Gabaldon, is a citizen of New Mexico
(Plaintiff) (State)
who presently resides at P.O. Box 25265 Alb, NM, 87125
(Mailing address or place of confinement)

2) Defendant Department of Justice is a citizen of
(Name of first defendant)
Albuquerque, New Mexico, and is employed as
(City, State)
Director, ~~Supervisor~~ Captain. At the time the claim(s)
(Position and title, if any)
alleged in this complaint arose, was this defendant acting under color of state law?
Yes ☐ No ☐ If your answer is "Yes", briefly explain:

3) Defendant _____ is a citizen of
(Name of second defendant)
_____, and is employed as
(City, State)
_____. At the time the claim(s)
(Position and title, if any)
alleged in this complaint arose, was this defendant acting under color of state.
Yes ☐ No ☐ If your answer is "Yes", briefly explain:

(Use the back of this page to furnish the above information for additional defendants.)

4) Jurisdiction is invoked pursuant to 28 U.S.C. §1343(3), 42U.S.C. §1983. (If you wish to assert Jurisdiction under different or additional statutes, you may list them below.)

I ask from there office to provide me with information about Civil right being violate. The there was over hundred Civil right violate, I need uptain an Attorney, by the way civil right be violate, I seeked every Attorney in this New Mexico. I am now

B. NATURE OF THE CASE

~~1) Briefly state the background of your case.~~

ask for information on these case. The reason that officer will or could not help was filed in federal court every 2 year since 2005 and is still on going to this date. I will need seal Case that has my name in it. My name might be David Garbalden, David A Garbalden, other people that used my name that were in forment. The office went me meet using my name, while Jail. Who was this person because, I was custody and was not talking to these officers But all people, were there saying that it not him, he right in Jail. They arrested them. I get Attack in so many different type, that lying face, me. Been dilling with Bio chemical in the Air, like smoke..

C. CAUSE OF ACTION

1) I allege that the following of my constitutional rights, privileges or immunities have been violated and that the following facts form the basis for my allegations: (If necessary, you may attach up to two additional pages (8 1/2" x 11") to explain any allegation or to list additional supporting facts.

A)(1) Count I: So, I need all these files, cause will (pro's). I will be my own Attorney and filing this.

(2) Supporting Facts: (Include all facts you consider important, including names of persons involved, places and dates. Describe exactly how each defendant is involved. State the facts clearly in your own words without citing leagl authority or argument.)

On DOJ online report Said, DAG 71 Asset forfeiture, DOJ 316, Also information with the information on CRT 123, Coordination and Review section. I will need the Complaint Alleging failure of DOJ Employee to provide the right for "Crime victim under the Crime Right Act 2004, Alternate version

B)(1) Count II:

Antitrusted Division - Complaint Alleging failure of Department of Justice "State law of new mexico of being victim.

(2) Supporting Facts:

This case in DDos - Attack of worm propageting through the network (NCCIC)

C)(1) Count III: At Walgreens, store #11959, Rx number: 797260 5201 Central Ave. NE, The entire report for officer, The intercom said, DC3 tell other police police offer the warning or problem. I need all information on that report. Here is evidence that, I was there getting vaccine report.

(2) Supporting Facts:

If the DCC3 was not for me' David A Gonzales, that became victim, and witness as well. Also on this contract that signed, personal this high light my sentence line missed the last work. I Just want point that out.

D) PREVIOUS LAWSUITS AND ADMINISTRATIVE RELIEF

1) Have you begun other lawsuits in state or federal court dealing with the same facts involved in this action or otherwise relating to the conditions of your imprisonment? Yes ☐ No ☒ If your answer is "YES", describe each lawsuit. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same outline.)

a) Parties to previous lawsuit.

Plaintiffs: _____

Defendants: _____

b) Name of court and docket number:

c) Disposition (for example: Was the case dismissed? Was it appealed? Is it still pending?

d) Issues raised: _____

~~e) Approximate date of filing lawsuit:~~ ______________________

~~f) Approximate date of disposition:~~ ______________________

2) I have previously sought informal or formal releif from the appropriate administrative officials regarding the acts complained of in Part C. Yes ☐ No ☒ If your answer is "Yes", briefly describe how relief was sought and the results. If your answer is "No," briefly explain why administrative relief was not sought.

Do to so much information, and officer that might be involved, I will not be sure when it will end, I best that, I planning on is March could be resoveled.

E. REQUEST FOR RELIEF

1) I believe that I am entitled to the following relief: I ~~a~~ need ~~Attor~~ Address under my name, That, I live at. feel Safe. If need to be move, I will talk to an officer request to be moved. This lawsuit is worth $100000000, ~~worth~~. If this Case ~~as~~ has to move to another state the state will have fund my movement too be house and transportation ~~to~~ due to me endigent. low on money.

David

~~Signature of Attorney (if any)~~

David Gabaldon

Signature of Petitioner

(Attorney by Pro'es)
David Anthony Gabaldon

Attorney's full address and telephone number. P.O. Box 25265
AlB NM 87125

DECLARATION UNDER PENALTY OF PERJURY

The undersigned declares under penalty of perjury that he is the plaintiff in the above action, that he has read the above complaint and that the information contained therein is true and correct. 28 U.S.C. Sec. 1746. 18 U.S.C. Sec. 1621. To best of my [illegible] I can answer, ~~[illegible]~~ I need make change later, I will file motion for that change.

Executed at 5ce Lomas NE 87102 on 9/16/16 2016
(Location) (Date)

[signature]
(Signature)

Name: David A Gabaldon

Store Number: 11959	**RxNumber:** 797260
Store Address: 5201 CENTRAL AVE NE	
ALBUQUERQUE, NM 87108	

Walgreens

Vaccine Administration Record (VAR) - Informed Consent for Vaccination*

Section A *Complete a separate VAR form for each administered vaccine.*

Patient Name: DAVID GABALDON **Date of Birth:** 03/21/1979 **Age:** 37 **Gender:** M **Home Phone:** (505) 344-2323

Home Address: 175 CANDELARIA NE ALBUQUERQUE, NM 87108 **Email Address:**

Walgreens will send immunization information from this visit to your doctor/primary care provider using the contact information provided below.

Primary Care Physician/Provider Name:

Phone: ________ **Address:** PO Box 25265 Albuquerque NM 87125

I want to receive the following immunization: FLUVIRIN MULTIDOSE VIAL 2016-17 5ML

Is the information in Section A above correct? Yes No **If no, please alert the pharmacy staff.**

Section B *The following questions will help us determine your eligibility to be vaccinated today.*

#	Question			
	All vaccines			
1	Do you feel sick today?	Yes	No	Don't know
2	Do you have any health conditions such as: heart disease, diabetes, or asthma? If yes, please list:	Yes	No	Don't know
3	Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal)? If yes, please list:	Yes	No	Don't know
4	Have you ever had a reaction after receiving an immunization including fainting or feeling dizzy?	Yes	No	Don't know
5	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?	Yes	No	Don't know
6	For women: Are you pregnant or considering becoming pregnant in the next month?	Yes	No	Don't know
	Live vaccines (Chicken pox, flu nasal spray, MMR®, oral typhoid, shingles, Yellow fever) Only answer these questions if you are receiving any immunizations listed above.			
7	Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:	Yes	No	Don't know
8	Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	Yes	No	Don't know
9	Are you currently on home infusions, weekly injections such as Humira (adalimumab), Remicade (infliximab) and Enbrel (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	Yes	No	Don't know
10	Are you currently taking high dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	Yes	No	Don't know
11	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	Yes	No	Don't know
12	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome, or thymoma), or had your thymus removed? (Yellow fever only)	Yes	No	Don't know
13	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	Yes	No	Don't know
14	Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR only)	Yes	No	Don't know
	Flu nasal spray (FluMist® Quadrivalent)			
15	Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	Yes	No	Don't know
16	Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (For FluMist only)	Yes	No	Don't know

Section C I cover by United Health Care.

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Walgreens, Duane Reade, Take Care Health Services, or DR Walk-in Medical Care, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provide[redacted] its staff, agents, successors, divisions, affiliates, [redacted] in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange [redacted] and (b) the applicable Provider may disclose my immunization information to the [redacted] or through the [redacted] to the [redacted], for purposes of public health reporting or to my health care providers enrolled [redacted] or purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using [redacted] or, as permitted by my state law, [redacted] (a) the disclosure of my immunization information by the applicable [redacted] and/or State Registry; or (b) [redacted] and/or State Registry [redacted] information with any [redacted]. The applicable Provider will, if [redacted] I understand [redacted] need to specifically consent, and to the extent required [redacted] state's law, by signing below, I hereby do consent to the applicable [redacted] entities and for the purposes described in this Informed Consent form. Unless I provide [redacted] services as well as [redacted] me after the time of service upon receipt of such invoice. [redacted]

Patient Signature: ________ (Parent or Guardian, if minor) **Date:** [redacted]

*Healthcare providers can be an immunization-certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, physician or physicians assistant.
**Patient care services at Healthcare Clinic at select Walgreens provided by Take Care Health Services, an independently owned professional corporation whose licensed healthcare professionals are not employed by or agents of Walgreen Co. or its subsidiaries, including Take Care Health Systems, LLC. Walgreen Co. and its subsidiary companies provide management services to provider practices, in-store clinics and worksite health and wellness centers.